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March 21, 2007

MEMORANDUM

TO: Providers of Community Support Services recently reviewed in the 2006/2007 Medicaid Audit of Community Support Services

FROM: Allen Dobson, MD

Mike Moseley

RE: DHHS Follow-Up Plan to 2006/2007 Medicaid Audit of Community Support Services

Your provider agency recently participated in a Medicaid audit as a component of DHHS Secretary Carmen Hooker Odom's focused system review of Community Support Services. Those reviews have identified several issues which require continuing examination and follow-up in order to assure that individuals who receive Community Support services are receiving what was designed and described in the service definition for those individuals to receive, and that you, as providers, have all the information you need to provide the service appropriately.

The results of the audits indicate there are providers of Community Support services who do not have a full understanding of either the service as it was intended to be provided, or a working knowledge of Medicaid documentation requirements, or a combination of both. Follow-up measures have been identified and are being implemented to address both of these areas of concern. They are referenced in a press release from the Secretary's Office which you may find at the following web site:
http://www.dhhs.state.nc.us/pressrel/3-13-07.htm

As you know, the audit tool being used for this review contains eleven (11) questions. The Division of Medical Assistance (DMA) and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) have reviewed the results of these audits, and applied a formula which weights the results to emphasize the clinical, programmatic and Medicaid documentation requirements which are most critical: These include (Audit Tool Question 2) a valid treatment/person centered plan; (Audit Tool Question 1) a valid service order; (Audit Tool Question 11b) an authorization for the service; and (Audit Tool Question 4) an appropriately signed progress note for the date of service.

The results of the application of this formula to the scores of the Medicaid audits then served as the basis for categorizing providers into three groups, with requirements for each group depending upon the group into which the provider scores fall. These groups are:

Group 1: Providers who scored 75% or higher on the overall Medicaid audit. For these providers:

1. DMA will recoup payment for any claims not fully documented.
2. The provider will be required to prepare/submit a corrective action plan.
3. The provider will be required to conduct a self-audit and repay Medicaid for any undocumented claims.
4. One representative of the provider agency will be required to attend training on Medicaid billing and documentation requirements.

Group 2: Providers who scored less that 75% on the overall, but 50% or greater on the above noted critical measures. For these providers:

1. DMA will recoup payment for any claims not fully documented.
2. The provider will be required to prepare and submit a Plan of Correction.
3. Local Management Entities (LMEs) with the assistance of DMH/DD/SAS audit staff will conduct a full record review of thirty (30) additional Medicaid records.
4. At least the CEO, CFO and QA Director of the provider agency will be required to attend training on Medicaid billing and documentation requirements.
5. DMA will withhold 5% of all Medicaid payments until demonstration of compliance to Plan of Correction and future billings are found to be in compliance with minimum documentation standards. At such time as the provider meets these conditions, the 5% Medicaid withholding will be discontinued retroactive to the date the 5% withholding was initiated.

Group 3: Providers who scored less that 50% on the above noted critical measures, or who had 4 or more records which did not contain notes for the events audited. For these providers:

1. DMA will recoup payment for any claims not fully documented.
2. DMA will refer to DMA Program Integrity and/or the Attorney General's Medicaid Investigative unit (MIU) for possible cases of provider fraud/abuse and initiation of the DMA provider rapid action response protocol.
3. The provider will be required to prepare and submit a Plan of Correction.
4. LMEs will conduct an endorsement review.
5. DMA will place the provider on "paper claim" status.
6. At least the CEO, CFO and QA Director of the provider agency will be required to attend training on Medicaid billing and documentation requirements.
7. DMA will withhold 25% of all Medicaid payments until demonstration of compliance to Plan of Correction and billings are in compliance to minimum documentation standards. At such time as the provider meets these conditions, the 25% Medicaid withholding will be discontinued retroactive to the date the 25% withholding was initiated.

Further explanation of the required responses in these three categories:

1. **"DMA will recoup payment for any claims not fully documented":** This is the normal process whereby audit results are routinely entered into a database at DMH, and the Program Integrity (DMA PI) Section of DMA accesses those records and sends routine requests for recoupment to the provider.
2. **"The provider will be required to prepare and submit a Plan of Correction":** This, again, is a modification of the routine process whereby Plans of Correction are required for compliance findings pursuant to the Medicaid audit. In this case, the process will be a little different, because it will be the LME which also participated in the Medicaid audits, who

will do the POC follow-up. The LMEs will receive specific training in this process from Accountability Staff who specialize in reviewing POCs. You will receive a report on your audit results within 45 days of the conclusion of the Community Support audits, and your POC will be required to be submitted within 30 days of the date you receive the report.

3. **"The provider will be required to conduct a self-audit and repay Medicaid for any undocumented claims"**: This is another routine tool used to assure compliance for Medicaid requirements, and also to underscore the importance of the provider quality assurance and quality improvement process. The provider will follow DMA PI protocol for self-assessment, and will submit voluntary payment for claims found to be non-compliance with Medicaid requirements. If a provider is required to submit repayment and does not do by May 1, 2007, DMA PI will conduct follow up and may, as deemed necessary, undertake a full provider record review.
4. **"LMEs with the assistance of DMH/DD/SAS and DMA audit staff will conduct a full record review of thirty (30) additional Medicaid records":** For providers who scores place them in Group 2, during the month of April, 2007, LMEs will conduct record reviews in three identified locations in the three regions. The LMEs will conduct the record reviews of those providers providing services within their catchment areas, and for whom the LME has monitoring responsibilities pursuant to 10 NCAC 27G.0608. Specific instructions on dates, appointment times, and locations will follow soon under separate cover.
5. **"The provider agency will be required to attend training on Medicaid billing and documentation requirements":** DMA and DMH/DD/SAS are planning regional training events to address the issues identified in the CS audits. Dates and times to follow soon under separate cover.
6. **"DMA will withhold 5% or 25% of all Medicaid payments until demonstration of compliance to Plan of Correction and future billings are found to be in compliance with minimum documentation standards":** DMA will maintain close contact with LMEs and DMH/DD/SAS as the Plan of Correction process unfolds. As POCs are received and approved and implementation of the POC verified and documentation training is completed DMA will be notified, and edits set in place to withhold these funds will be lifted.
7. **"LMEs will conduct an endorsement review":** LMEs will conduct full endorsement reviews for providers who are required to undergo this review. The DMH/DD/SAS LME System Performance Team will conduct special training for LMEs on any revisions which have been made to the endorsement checksheets.
8. **"DMA will place the provider on 'paper claim' status."** Under this scenario, the provider would have to attach all of the appropriate documentation to the paper claim, submit that claim to DMA, and DMA staff would review and approve for payment. More specific instructions will follow under separate cover.

Several other communications will come your way soon, including specifics about the audits and training events. Should you have questions about the content of this memorandum, please contact Jim Jarrard at DMH/DD/SAS (jim.jarrard@ncmail.net) or Marcia Copeland at DMA (Marcia.Copeland@ncmail.net).

cc: Secretary Carmen Hooker Odom
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